IN THE UNITED STATES DISTRICT COURT

FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

GRETCHEN S. STUART, M.D.; *et al.*, Plaintiffs, v. JANICE E. HUFF, M.D. *et al.*, Defendants.	Civil Action No. 1:11-cv-804-CCE

DECLARATION OF MARTIN J. MCCAFFREY, M.D., IN SUPPORT OF PROPOSED DEFENDANT INTERVENORS' MOTION FOR INTERVENTION

I, MARTIN J. MCCAFFREY, M.D., declare as follows:

1. I am not a party or related to a party in this action. I am over the age of eighteen and am competent to testify. I am a physician licensed to practice medicine in North Carolina and California and Board Certified in Neonatal-Perinatal Medicine. I am a Clinical Professor of Pediatrics in Neonatal-Perinatal Medicine at the University of North Carolina at Chapel Hill and Director of the Perinatal Quality Collaborative of North Carolina. I am a practicing neonatologist at North Carolina Children's Hospital. I routinely counsel women with high risk pregnancies and regularly rely upon ultrasonography in my practice. My medical education, training, publications, and

qualifications are set forth in my *Curriculum Vitae*, a true and correct copy of which is attached as EXHIBIT A hereto and incorporated herein by this reference.

2. I have practiced as a neonatologist for 16 years. I have spent 20 years as a U.S. Navy physician, 11 as a neonatologist. After retiring from active military service in 2006 as a Navy Captain, I joined the faculty of the UNC School of Medicine.

3. I have read the Complaint filed herein and the recently enacted "WOMAN'S RIGHT TO KNOW ACT" being challenged in that Complaint on the various grounds set forth in this action. (H.B. 854, enacted July 28, 2011, N.C. SESSION LAW 2011-405, the "Act"). I seek to intervene as a defendant-intervenor in this action. I am knowledgeable of the facts set forth herein, and if called to testify would do so, as follows.

4. Supporting maternal autonomy and providing accurate and complete information so a woman can make a truly voluntary and fully informed decision regarding abortion is the responsibility of all providers engaged in neonatal-perinatal medicine. I seek intervention as a defendant-intervenor in this action on my own behalf, both personally and as a physician, and on behalf of my patients. I do not represent the UNC Chapel Hill School of Medicine in this case in any official capacity.

Neonatology and Prematurity

5. The provision of neonatal intensive care is in large part dedicated to services rendered to premature infants and their families. Our NICU at UNC Chapel Hill School of Medicine has 55 beds. We run at 90% occupancy and on any given day our NICU cares for 35 infants battling the complications of prematurity.

6. Premature birth is a serious health problem in the United States. According to the most recent data from the March of Dimes, about 12.8 percent of babies (more than half a million a year) are born prematurely in the United States. The rate of premature birth has increased by 36 percent since the early 1980s. According to 2005 data, the annual societal economic burden associated with preterm birth was $26.2 billion. INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCE, *Preterm Birth: Causes, Consequences, and Prevention* (National Academies Press, Washington, D.C., 2006) (hereafter "IOM2006 REPORT").

See http://www.nap.edu/openbook.php?record_id=11622&page=1.

7. Premature babies are at increased risk for newborn health complications, such as breathing problems, and even death. Most premature babies require care in a newborn intensive care unit (NICU), which has specialized medical staff and equipment that can deal with the multiple problems faced by premature infants.

8. Premature babies also face an increased risk of lasting disabilities, such as mental retardation, learning and behavioral problems, cerebral palsy, lung problems and vision and hearing loss. Recent studies suggest that premature babies may be at increased risk of symptoms associated with autism (social, behavioral and speech problems). Limperopoulos, C., et al. *Positive Screening for Autism in Ex-Preterm Infants: Prevalence and Risk Factors*. PEDIATRICS, 2008; 212: 758-765; Schendel, D., and Bhasin, T.K., *Birth Weight and Gestational Age Characteristics of Children with Autism, Including a Comparison with Other Developmental Disabilities*. PEDIATRICS, 2008; 121: 1155-1164.

9. Studies also suggest that babies born very prematurely may be at increased risk of certain adult health problems, such as diabetes, high blood pressure and heart disease. Hovi, P., et al. *Glucose Regulation in Young Adults with Very Low Birthweight*. NEW ENGLAND JOURNAL OF MEDICINE, 2007; 356: 2053-2063.

10. More than 70 percent of premature babies are born between 34 and 36 weeks gestation. About 12 percent of premature babies are born between 32 and 33 weeks gestation, about 10 percent between 28 and 31 weeks, and about 6 percent at less than 28 weeks gestation. IOM2006 REPORT.

11. The most serious medical complications occur in the most premature infants. Based on the most recent Vermont Oxford Network data for infants < 32 weeks gestation, their average hospital stay is 70 days. The overall mortality for infants in this gestational age group is 16%. *See* http://www.vtoxford.org.

12. In North Carolina very preterm birth impacts the black community at 2.1 times the rate of that seen in the white community.

See http://www.schs.state.nc.us/SCHS/births/matched/2008/all.html.

13. Prematurity accounts for 28% of black infant mortality and 17% of white infant mortality in North Carolina. *See*

http://www.schs.state.nc.us/SCHS/deaths/ims/2009/table7.html

14. Mothers of premature infants in my practice often ask me why their child delivered prematurely. I typically review the commonly discussed associations with prematurity which include a prior preterm infant, infection, and smoking. I will review

the mother's prenatal course with her and we often find that none of the commonly discussed risk factors are present.

15. Based on Guttmacher Institute reports, in approximately 25% of these cases an association is present which, in my anecdotal experience, most women are unaware of. If the mother is black there is a 35% chance that this other factor associated with her infant's prematurity may be present.

See http://www.guttmacher.org/pubs/fb_induced_abortion.html.

16. I then undertake the delicate task of informing the mother that medical literature over the past 30 years has identified that a previous abortion is associated with a 63% increased risk for a very preterm birth in a future pregnancy. This risk rate is for a single induced abortion. I explain that the risk for prematurity posed by abortion increases with the number of abortions. A history of two or more prior abortions is reported to increase the risk for a very preterm birth by 93%. Shah P. et al. *Induced Termination of Pregnancy and Low Birth Weight and Preterm Birth: A Systematic Review and Meta-analysis* BRITISH JOURNAL OF OBSTETRICS & GYNAECOLOGY 2009; 116:1425-1442. Swingle HM et al. *Abortion and the Risk of Subsequent Preterm Birth: A Systematic Review with Meta-analyses* JOURNAL OF REPRODUCTIVE MEDICINE 2009; 54:95–108.

Abortion and Prematurity

17. The use of suction aspiration to perform first trimester abortions is one of the most commonly performed surgical procedures in America.

18. The safety and potential harmful effects of suction aspiration were not studied prior to its introduction into medical practice in the United States in 1973. The standard for new medical procedures or therapies is a presumption of the likelihood of adverse risk until demonstrated that such risk does not exist via animal and human studies. Since there were no animal studies demonstrating the safety or potential effects of suction aspiration, it is critical that we objectively evaluate the outcomes data regarding abortion that has accrued over the past 38 years.

19. Prematurity is a complex problem with multiple potential causes. The 2006 IOM Report is the standard reference point for discussions of preterm birth. It discusses the association of prematurity with a variety of conditions. While the report showcases how little we know about preventing preterm birth, Table B-5 identifies "immutable medical risk factors associated with preterm birth, including: "prior first trimester induced abortion." (p. 625)

See http://www.nap.edu/openbook.php?record%20id=11622&page=625.

20. Today there are 122 studies, including two gold standard studies, meta-analyses, demonstrating increased risk for preterm and very preterm birth. Swingle HM et al. *Abortion and the Risk of Subsequent Preterm Birth: A Systematic Review with Meta-analyses* JOURNAL of REPRODUCTIVE MEDICINE 2009; 54:95–108); Shah P. et al. *Induced Permination of Pregnancy and Low Birth Weight and Preterm Birth: A Systematic Review and Meta-analysis* BRITISH JOURNAL OF OBSTETRICS & GYNAECOLOGY 2009;116:1425-14429.

21. There are particular communities which are remarkable demonstrations of this association. In North Carolina black women experience 2.1 times the rate of extremely preterm births and also have a 2.5 times higher rate of abortion than those seen in the white community.

See http://www.schs.state.nc.us/SCHS/births/matched/2008/all.html; http://www.schs.state.nc.us/SCHS/data/pregnancies/2009/rates.pdf.

22. A looming concern is the number of repeat abortions, an issue often unaddressed in informed consent. Of women obtaining abortions today, half have had at least one previous abortion.

See: http://www.guttmacher.org/pubs/fb_induced_abortion.html. Results from the EUROPOP study were unequivocal: "previous induced abortions were significantly associated with preterm delivery and the risk of preterm birth increased with the number of abortions." Ancel, P-Y, et al. *History of Induced Abortion as a Risk Factor for Preterm Birth in European Countries*: *Results of the EUROPOP Survey*. HUMAN REPRODUCTION 2004; 19: 734-740.

23. The scientific evidence is clear and unmistakable. Abortion is associated with prematurity, but Planned Parenthood and The American College of Obstetrics and Gynecology (ACOG) have yet to inform American women. Planned Parenthood North Carolina reports "safe, uncomplicated abortion does not cause problems for future pregnancies such as premature birth." http://www.plannedparenthood.org/health-topics/pregnancy/thinking-about-abortion-21519.htm. ACOG states, "Most experts agree that one abortion does not affect future pregnancies."

http://www.acog.org/publications/faq/faq043.cfm#5. In light of the considerable number of repeat abortions, ACOG's statement is equivocal and misleading. Neither of these organizations accurately represents the current science regarding abortion and its association with preterm births. As a result, many women who elect abortion do so in ignorance of any future risk to childbearing.

Personal Impact of The North Carolina Women's Right to Know Act

24. When the known abortion and prematurity link is not conveyed, women are denied their basic information right and patient autonomy is sacrificed. Informed consent is not possible under these conditions. Physicians have an ethical and legal duty to fully inform women considering an abortion. The effects of prematurity are significant and lasting, and women considering an abortion have the right to know of this known associated risk to future childbearing. The relationship of cigarette smoking to preterm birth according to IOM is "modest and inconsistent," yet the Surgeon General cautions expectant mothers with warnings on cigarette packages. IOM 2006 Report. Despite the demonstrable association of the abortion prematurity link, there is silence from health leadership.

25. The Act specifically requires that 24 hours prior to receiving an abortion, a woman must be informed of the particular medical risks associated with abortion, including the "danger to subsequent pregnancies, including the ability to carry a child to full term." § 90-21.82 (1) b. This provision and others in the Act, conform to the considerable medical evidence that women's health care decision-making should be guided by accurate and complete medical information that a reasonable patient would

deem material. *See* Coleman PK et al. *Women's Preferences for Information and Complication Seriousness Ratings Related to Elective Medical Procedures*. JOURNAL OF MEDICAL ETHICS 2006; 32:435-438.

26. If this case is decided adversely to the State and the Act is declared unconstitutional on the basis that the informational and ultrasound requirements and disclosures are ruled misleading, ideological, vague and inaccurate, as plaintiffs seek, I am personally affected in the most egregious manner and in many ways. I now seek to intervene in this matter so that my own interests and those of my patients are properly protected, litigated and advanced.

27. I have a personal and professional interest, and a legal, professional and moral duty to provide accurate truthful disclosures to mothers I counsel and the families of my patients. Commensurate with these interests and duties I have a right to speak freely and accurately. While I have a keen interest in protecting my own rights and interests, it is also my obligation to protect the rights and interests of families I care for and their future children. My rights and interests are inexplicably connected to that of my patients and their families. In short, I have a right and an obligation to tell the truth. Pregnant patients I counsel have the right to know the medical realities of the stage of their pregnancy including the right to be informed of the corresponding fetal development as depicted in ultrasound imaging. They also have the right to receive full and complete disclosure of the risks abortion creates for future pregnancies.

28. If Plaintiffs were to succeed in this lawsuit and have the Act declared unconstitutional because the Statute required non-truthful, vague or misleading facts or

mere ideology, my interests would be adversely affected. It would constitute a declaration that all of the consultation I have provided to mothers and families of preterm infants was false or misleading. This would immediately subject me to civil liability and potential disciplinary action by the state medical regulatory authority, including the possibility of suspension or revocation of my license to practice medicine. It would force me to alter my consultations, requiring me to make false and misleading disclosures. It would compel me to stop giving accurate factual and medical explanations. It would prevent me from speaking freely on what I know is truthful and accurate information. If I continued to give what I know is truthful and accurate facts, I would be immediately subject to all of the above sanctions, not just for past consultations with pregnant women, but for present and future consultations as well. Because of the order and decision already entered in this case which states that the plaintiffs have a fair chance of success, I am already exposed to all of these sanctions and liabilities and will continue to be exposed. It is an untenable circumstance in which to be placed. A number of facts and expert opinions that are directly contradicted by factual allegations and expert opinions are being alleged in this litigation and have already been offered in evidence by the Plaintiffs and cited by the Court in this case. As a direct result, in order to adjudicate the common issues of law and fact raised by the complaint in this matter, I find that I must protect my own legal interests, and that of my current and future patients' interests by becoming a defendant-intervenor in this litigation.

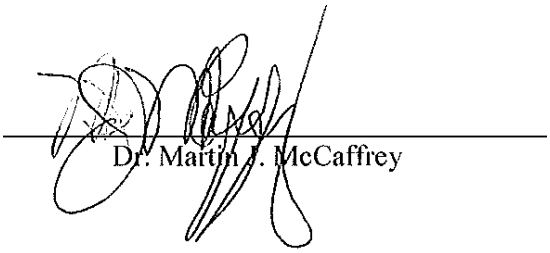
29. In addition to my rights and interests at stake here, the rights and interests of pregnant patients I counsel will also be adversely affected. Those rights and interests

depend almost entirely upon the truthful and accurate disclosures being given to them in order for them to make informed and voluntary health care decisions. Without accurate and truthful disclosures about abortion, their pregnancy course and fetal development, my patients will have incomplete information and be at risk for uninformed consent.

30. Restricting my ability to fully disclose the risks of abortion to pregnant mothers will also subject infants born to these post-abortive mothers to the potentially preventable morbidity and mortality of prematurity. The literature suggests that up to 31% of premature births may be a result of abortion. As a neonatologist, restricting my ability to report the known association of abortion with prematurity to a pregnant mother considering abortion is unconscionable.

31. Accordingly, I find that only I can properly protect my legal interests and the interests of my patients, and properly adjudicate the common questions of law and fact that my claims and defenses share with claims and defenses being asserted in this action, by intervening in this action as a defendant intervenor. As a defendant-intervenor I will do nothing to unduly delay or prejudice the adjudication of the original parties' rights in this action.

I declare under penalty of perjury of the laws of the United States that the foregoing is true and correct. Executed on November 1, 2011.



Dr. Martin J. McCaffrey

EXHIBIT A:

Curriculum Vitae

of

Martin J. McCaffrey, M.D.

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Martin John McCaffrey
M.D., CAPT USN (Ret.)
Curriculum Vitae

Personal Information

Martin J. McCaffrey
1008 Adams Mountain Rd
Raleigh, NC 27614
(919) 619-1422

Education

Postdoctoral Fellow in Neonatology	University of North Carolina School of Medicine	July 1 1995	Neonatology
Pediatric Residency	Naval Hospital San Diego	July 1 1989	Pediatrics
M.D	Albany Medical College	May 22 1986	M.D.
B.S.	University of Connecticut	May 23 1982	Biology

Licensure

California G65979 (Current)
North Carolina 54967 (Current)

Board Certifications

American Board of Pediatrics, BC Pediatrics (Current)
American Board of Pediatrics, BC Neonatal Medicine (Current)
Neonatal-Perinatal Medicine

Professional Experience and Employment History

Perinatal Quality Collaborative North Carolina (PQCNC)	Director	2006-Present
Neonatologist	Professor of Pediatrics	2011-Present

Professional Experience and Employment History (Cont)

Neonatologist	Associate Professor of Pediatrics	2006-Present
Uniformed Services University of the Health Sciences	Assistant Professor of Pediatrics	1999-Present
Specialty Consultant to the Navy Surgeon General	Specialty Leader (CDR&CAPT)	1997-2006
Neonatologist Naval Medical Center San Diego	Division Head (CDR &CAPT)	1996-2006
Neonatologist Naval Medical Center San Diego	Staff Neonatologist (CDR)	1995-1996
General Pediatrician Naval Hospital Guam	Department Head	1989-1992
Pediatric Chief Resident Naval Hospital San Diego	Chief Resident	1988-1989

Honors and Awards

August 2010	Recipient North Carolina Perinatal Association's *Baby Bootie Legislative Award* - "honors outstanding legislators, individuals, or organizations who take leadership in sponsoring and supporting legislation as well as in funding and/or preserving funds that go to improve the health of mothers and babies."
June 2006	Meritorious Service Medal
May 2004	Promoted to CAPT US Navy
April 2004	Navy Commendation Medal
February 2003	*Hero of Tricare*; Selected by Assistant Secretary of Defense for Health Affairs
May 1999	Promoted to CDR US Navy
June 1998	UCSD Family Practice Residency Outstanding Teacher
June 1996	Teacher of the Year, Pediatrics Department, Naval Medical Center San Diego
March 1994	Promoted to LCDR US Navy

Honors and Awards (Cont)

June 1992	Navy Achievement Medal
May 1985	Selected for Alpha Omega Alpha
July 1984	Military Health Professions Scholarship

Bibliography

Books/Chapters

Wheeler D and McCaffrey M. Resuscitation of the Newborn in the Delivery Room. Conn's Current Therapy, 2007 and 2008 edition.

Refereed Papers/Articles

McCaffrey MJ. Lethality begets lethality. *J Perinatol.* 2011 Jun;31(6):387-91.

Bookman L, Troy R, McCaffrey M, and Randolph G**.** Using quality-improvement methods to reduce variation in surfactant administration *Qual Saf Health Care* doi:10.1136/qshc.2009.034967

Wood KS, McCaffrey MJ, Donovan JC, Stiles AD, Bose CL**.** Effect of initial nitric oxide concentration on outcome in infants with persistent pulmonary hypertension of the newborn. Biol Neonate 1999;75(4):215-24

Kinsella JP, Walsh WF, Bose CL, Gerstmann DR, Labella JJ, Sardesai S, Walsh-Sukys MC,McCaffrey MJ, Cornfield DN, Bhutani VK, Cutter GR, Baier M, Abman SH. Inhaled nitric oxide in premature neonates with severe hypoxaemic respiratory failure: a randomized controlled trial. Lancet 1999 Sep 25;354:1061-5

McCaffrey MJ, Bose CL, Reiter PD, Stiles AD. Effect of L-arginine infusion on infant's with persistent pulmonary hypertension of the newborn. Biol Neonate 1995;67:240-243.

In Press/Submitted

Sofia R Aliaga, Pillip B Smith, Wayne A Price, MD, Thomas S Ivester, Kim Boggess, Sue Tolleson-Rinehart, Martin J McCaffrey, and Matthew M Laughon. Regional Variation in Late Preterm Births in North Carolina (submission October 2010 to American Journal Obstetrics and Gynecology)

Refereed unpublished oral presentations and/or abstracts

Sofia R Aliaga, Pillip B Smith, Wayne A Price, Thomas S Ivester, Kim Boggess, Sue Tolleson-Rinehart, Martin J McCaffrey, and Matthew M Laughon. Regional Variation in Late-Preterm Births in North Carolina: Poster Presentation AAP Meeting, San Francisco, 2010

Teaching Record

Course Director (Sept 2009-Sept 2010)	CABSI and 39 Weeks Learning Session Series (Series included Six Learning Sessions over 12 months, 40-80 attendees per session. Attendees from across the state including Doctors, nurses, administrators, family members and family support staff. Course time was 42 hours. CEUs obtained through UNC CME Office.)
Lectures/Courses At UNC	
NICU Skills Course for Residents (May 2010 & annually)	Three hour skills lab for rising residents, includes intubation, chest tube placement, and expectations overview
UNC Resident Board Review Course: Neonatal Section	Overview of key neonatal topics, Annual, 3 hours
UNC SOM Third Year Genetics Track	"Down Syndrome", Annual, 1 hour
Neonatal Fellow Conference Presentations	PPHN, Meconium Aspiration, Annual 1 hour

Continuing Education/ Lectures Outside UNC

Medical Students for Life Annual Meeting	Dallas, Tx April 2011	"Blessed by Down Syndrome" Keynote Speaker
Kentucky Annual March Of Dimes Meeting	Louisville, KY Nov 2010	"Transforming Perinatal Healthcare: The 39 Weeks Experience"
Massachusetts Annual March of Dimes Conference	Boston, Ma Sept 2010	"Transforming Perinatal Healthcare: The 39 Weeks Experience"
AHEC Eastern Carolina	Greenville, NC March 2010	"Making North Carolina the Best Place to be Born: The PQCNC Journey"

Vermont Oxford Network Quality Congress	Washington, DC Dec 2009	"We're Having a PQCNC"

Teaching Record (Cont.)

Kentucky March of Dimes Regional Meeting	Ashland, KY Feb 2010	"The Perinatal Quality Collaborative of North Carolina"
AHEC Charlotte	Charlotte, NC October 2009	"Making North Carolina the Best Place to be Born: The Quality Journey"
Gaston Memorial Hospital	Gastonia, NC September 15, 2009	"The Perinatal Quality Collaborative of North Carolina"
March of Dimes "Big Five" Meeting	Webinar April 2009	"The Perinatal Quality Collaborative of North Carolina"
Vermont Oxford Network Quality Congress	Washington, DC December 2008	"Setting the PQCNC Table"
Inaugural Meeting of The Tennessee Initiative for Perinatal Quality Care (TIPQC)	Nashville, TN November 2007	"The PQCNC Experience"
American Board of Pediatrics Subspecialties Meeting	Durham, NC July 2007	"The Perinatal Quality Collaborative of North Carolina…aka PQCNC"
Vermont Oxford Network Quality Congress	Washington, DC Dec 2007	"Updates for the NC Perinatal Quality Collaborative"
American Board of Pediatrics Summit on National QI Project and MOC	Washington, DC Dec 2007	"The PQCNC"
Vermont Oxford Network Quality Congress	Washington, DC Dec 2006	"The North Carolina Perinatal Quality Collaborative"
Regional Tricare Meeting	Baltimore, MD May 2004	"Pricing Perinatal care"

National Tricare Conference	Washington, DC Feb 2004	"Pricing Perinatal Care"

Teaching Record (Cont.)

Regional Tricare Meeting	Lousiville, KY Sept 2003	"A Family Centered Military Perinatal Healthcare System"
National Tricare Conference	Washington, DC Feb 2003	"Transition to a Family Centered Military Perinatal Care System"
National Tricare Conference	Washington, DC Feb 2002	"Needed Changes in Military Perinatal Care"

Grand Rounds – UNC

UNC Department of Anesthesia	UNC Chapel Hill May 2010	"Peeling the PPHN Onion"

Grand Rounds – outside UNC

Department of Pediatrics Naval Medical Center San Diego	San Diego, Ca Sept 2009	"Quality and the PQCNC Transformation"

Other Presentations – UNC

Center for Maternal Infant Health	UNC Chapel Hill Sept 2007	"PQCNC"
Center for Maternal Infant Health	UNC Chapel Hill Mar 2008	"Tricare and Perinatal Care"
UNC Department of Pediatrics	UNC Chapel Hill March 2007	"PPHN"

Mentorships/Graduate Supervision

Scholarly Oversight Committee	Honored to serve in this capacity for 2 UNC neonatal fellows 2007-2010

Teaching Record (Cont.)

Core Faculty North Carolina Children's Center for Clinical Excellence	2009-2011
Advanced Improvement Methods Workshop Center for Health Care Quality Cincinnati Children's Hospital	Annual mentoring of 1 student since 2009

Clinical Teaching- Lectures

NCCC Monthly Lecture Series for On Service Residents	6-12 one hour lectures/year, including RDS, Fluid and Electrolytes, ROP/IVH, Metabolic Disorders

Attending on Clinical Service

Daily rounds
Each year, I spend a total of 12-15 weeks on service attending in the Newborn Critical care Center. I teach on rounds approximately 3 hours/day

Night rounds
Each night that I am on call in the hospital (approximately once per month), I teach nurse practitioners, residents and interns for approximately 2 hours

Direct supervision of procedures
I participate in the direct supervision and teaching of the following procedures for fellows, residents and interns: intubation, chest tube placement, central line placement (umbilical arterial catheter and umbilical venous catheters), thoracocentesis, pericardiocentesis, pleurocentesis etc

Direct supervision of the Delivery room care
I participate in the direct supervision and teaching to fellows, residents and interns, in delivery room care and resuscitation ranging from routine newborn care (suctioning, drying,

warming and stimulating) to intubation, chest compressions, emergency central line placement, and the administration of epinephrine.

Student Preceptorship

College Students	Two full mornings mentoring students in the NICU
UNC Greensboro	(Spring 2010)

Grant Support

Maternal Block Grant via North Carolina Department of Health: $250,000 to the PQCNC for the period July 2011-July 2012. Dr. McCaffrey is PI for this grant.

HRET/AHA Subcontract to PQCNC to Lead National Catheter Associated Bloodstream Infection Project:$210,000 to PQCNC to lead eight states and 80 NICUs in this one year project. (August 2011-Augist 2012)

Neonatal Outcomes Improvement Project (NOIP) Grant: $625,000
Awarded by Center for Medicare/Medicaid Services (CMS) to the North Carolina DMA (2008-2011), PQCNC is the subcontractor with DMA for clinical work. Dr. McCaffrey is the PI for this grant.*

UNC Investments for the Future (IFF) Grant: $655,000
Awarded by the Dean UNC School of Medicine (2008-2011), Dr. McCaffrey is the PI for this grant.*

*Salary support in 2010 totals 50% between the Maternal Block, HRET, NOIP, and IFF Grants.

North Carolina Legislature Line Item Recurring Budget Support, $50,000
2008-2010, "PQCNC Funding"

North Carolina Legislature Line Item One Time Budget Support, $250,000
2009, "PQCNC Funding"

Wyeth Laboratories Fellowship Grant, $5000
1994-1995 “Effect of a Multiple-Dose Regimen of L-arginine on Infants with Persistent Pulmonary Hypertension of the Newborn” Dr. McCaffrey PI for this award.

University of North Carolina Hospital Innovative Grant, $1000
1992-1993 “Treatment of Persistent Pulmonary Hypertension of the Newborn with Nitric Oxide” Dr. McCaffrey PI for this award.

North Carolina American Lung Association Grant, $2500
1994-1995 “Effects of Nitric Oxide in the Respiratory Distress Syndrome”
Dr. McCaffrey PI for this award.

Professional Service

Discipline

2010-Present	Member NC Department of Public Health Hospital Acquired Infection (HAI) Committee
2010-Present	Member of Department of Public Health Subcommittee on Economic Impact of HAI
2010-Present	Member Expert Committee of the AHA’s Health Research and Educational Trust (HRET) National NICU Panel for Stopping Blood Stream (SBI) Infections
2010-Present	Chair of the National Perinatal Information Center (NPIC) Advisory Committee
2008-Present	Member NC Perinatal Health Committee
2008	Invited Expert Surgeon General's Conference for the Prevention of Prematurity, Washington, DC, June 2008.
2008-Present	Member Joint Commission Perinatal Core Measures Steering Committee
2007-Present	Member National Quality Forum (NQF) Perinatal Steering Committee
2006-Present	Member Neonatal Perinatal Information Center Advisory Board
2002-Present	STABLE Board of Directors

UNC Hospitals

2010-Present	Co-Chair UNC Quality for Women and Infants Performance Improvement Committee (QWIPIC)
2009-2010	Member UNC Quality for Women and Infants Performance Improvement Committee (QWIPIC)

Professional Service (Cont)

Site Visits/Review Panels

2006-Present	Conducted site visits to 24/28 PQCNC Member Hospitals
2008-Present	Reviewer for "Quality and Safety in Healthcare", 2008-Present
2008-Present	Reviewer for International Forum on Quality and Safety in Health
2008-Present	Reviewer for "Journal of Pediatric Infectious Disease"
2008-Present	Reviewer for "Pediatrics"
2004-Present	Reviewer "American Family Physician" (Journal of the American Academy of Family Practice)